

Quality Account

Assuring you of the quality of services at Ashford and St Peter's
Hospitals NHS Foundation Trust

2010/2011

About this document

What are Quality Accounts and why are they important?

Quality Accounts are annual reports to the public about the quality of services that providers of healthcare deliver and their plans for improvement. The purpose of Quality Accounts is to enable:

- patients and their carers to make well informed choices about their providers of healthcare;
- the public to hold providers to account for the quality of the services they deliver;
- Boards of NHS providers to report on the improvements made to their services and set out their priorities for the following year.

There are three important quality improvement areas:

- safety;
- patient experience and;
- clinical effectiveness.

Our Quality Account contains information about the quality of our services, the improvements we have made during 2010/11 and sets out our key priorities for next year (2011/12). This report also includes feedback from our patients, governors and commissioners on how well they think we are doing.

Foreword from the Chief Executive

Welcome to our second Quality Account for Ashford and St Peter's Hospitals NHS Foundation Trust. This publication describes just how seriously we consider quality and safety issues in our two hospitals and how we work continuously to make the right improvements. We want both patients and visitors to feel confident of the quality of our services, and this Quality Account sets out our priorities for improvement and details how we have performed against some key quality measures over the last year.

However, it's important to note that this is just one part of our approach to improving quality, and we have in place a number of other monitoring processes and initiatives – for example our monthly Quality Report which goes to the Trust Board – which help us to make continual improvements on behalf of our patients.

In December 2010 we became a Foundation Trust which in itself is a measure of the quality and safety of our services and shows the confidence Monitor, the regulatory body for Foundation Trusts, has in our organisation. We were the first Trust to become a foundation organisation under new, tougher criteria set by Monitor, which is a further indicator of the high levels of quality and safety in our two hospitals.

The Board at Ashford and St Peter's reviews a detailed quality report every month at our public board meeting and take it extremely seriously. To make sure the Board is fully engaged with care right on the front line, we regularly invite patients to come and present to the Board – describing their individual experiences, good and bad. Regular walkabouts around our hospitals, talking to patients and staff, also help our Board members have a good understanding of what it is like to be a patient in our hospitals.

2010/11 has been another very good year for Ashford and St Peter's with some particular highlights in terms of quality achievements; our maternity services were awarded the highest standard for patient safety, the *Clinical Negligence Scheme for Trusts* Level 3, which is an assurance that we have put all the right processes and improvements in place to make our services as safe as possible. And in November 2010 the Clinical Pathology Accreditation Office once again confirmed our pathology services had all retained their fully accredited status, the only pathology service within Surrey and Sussex to achieve this.

We were particularly pleased that results from the *Dr Foster Good Hospital Guide for 2010* showed that once again Ashford and St Peter's are demonstrating lower than average mortality ratios (90 overall against a norm of 100), with the joint fifth lowest ratio nationally for a 'basket' of the most common causes of death in hospital – stroke, heart attack, congestive heart failure, pneumonia and falls.

We have also been recently nominated as a CHKS top 40 hospital as part of their 2011 Top Hospitals Programme, based on an evaluation of a number of markers including safety, clinical effectiveness, outcomes, efficiency, patient experience and quality of care which is a great achievement for the Trust.

Earlier this year a complaint about a patient attending St Peter's Hospital in 2007 was featured in the Health Services Ombudsman's report about care of the elderly. This case highlighted several serious issues and we have worked closely with the Ombudsman to draw up an action plan of improvements which are now being closely monitored by our Board. Since 2007, we have made significant improvements, with close attention being paid to discharge planning, nutrition (particularly for elderly patients with complex needs) and improved communication training for staff. However, there is still more to do on these issues and this is reflected in our priorities going forward for 2011/12.

This case has drawn our focus even more sharply to our commitment to improving patient experience and, in may 2011, we launched a Trust-wide programme, 'Living our Values', which will involve every member of staff across our two hospitals. By exposing staff to real patient stories, and the emotions they generate, the programme will demonstrate the impact each and every one of our staff can have on a patient's experience.

Overall I am extremely pleased with the continued improvements Ashford and St Peter's continues to make in its vision to become one of the best healthcare Trust's in the country. Our performance to date and our quality reports confirm that our two hospitals continue to be safe places for patients to receive care and treatment.

The information provided in this Quality Account is provided from our data management systems and our quality improvement systems and to the best of my knowledge is accurate, and provides a true reflection of our organisation.



Andrew Liles
Chief Executive

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Our priorities

We want to ensure the highest possible standards of quality for our patients, meeting and exceeding their expectations in terms of patient experience, safety and clinical outcomes. Each year we set ourselves a number of key priorities under each of these headings which helps us to focus on those areas most in need of our attention and continued vigilance.

In this section we describe our achievements against each of the key priorities we set ourselves last year and our plans for further improvement this year.

Review of our key priorities for 2010/11

Last year we set ourselves six priorities under the following headings:

Improving patient experience:

1. Increasing our accountability in meeting our patients' needs
2. Improving all aspects of communication with our patients

Safety:

3. Reducing hospital acquired infections
4. Reducing falls

Clinical outcomes:

5. Operating on patients with broken hips more quickly
6. Improving the effectiveness and efficiency of a patient's hospital stay

Improving our patient experience

Ashford and St Peter's Hospitals NHS Foundation Trust is recognised as having very good clinical outcomes. However, we know that the experience of some of our patients is not as good as we would like it to be. Improving patient experience is one of our key corporate objectives.

In last year's Quality Account we stated that our goal was to improve our patient survey results so that by 2012 we are among the top performing Trusts in the country. We chose two key priorities to help move towards this which can be measured specifically through a reduction in patient complaints and through the results of the national patient survey:

Priority 1 - Increasing our accountability in meeting our patients' needs

Why is this a priority?

We know it is crucial to have a clear understanding of how our patients feel about our services if we are to meet their expectations and provide a first class patient experience. Being more accountable to what our patients are telling us means we will make the right improvements to meet their needs.

What did we do in 2010/11?

- We introduced a new questionnaire, 'Your Feedback', to give to patients on discharge so they can report back quickly on their individual experience. Following analysis full reports and individual patient comments are shared with staff. Ward teams are then encouraged to discuss the feedback and develop any relevant actions in response.

Since the new questionnaire was introduced we have had over 3,500 forms returned and, over the year, have seen improvements in the overall experience being reported with an increasing number of patients saying they would recommend us to family and friends.

- National patient surveys provide the Trust with a good opportunity to obtain feedback from patients and to know how well we are doing. We take the results of the surveys very seriously and following the results compile detailed action plans as a direct response to what patients are saying. In 2010, 850 patients were invited to give feedback on their inpatient experience. Collated results were compared nationally with 160 other acute and specialist Trusts and action plans – for the Trust overall and then more detailed plans for each of our clinical divisions – were drawn up in direct response.
- The visibility and engagement of our senior staff with our patients remains a priority. At the highest level, making sure the Board is fully engaged with care right on the front line, we regularly invite patients to come and present to the Board – describing their individual experiences, good and bad. Regular walkabouts around our hospitals, talking to patients and staff, also help our Board members have a good understanding of what it is like to be a patient in our hospitals.

More widely, Divisional General and Clinical Managers undertake regular walkabouts and 'spot checks' of their areas making sure they pick up and respond to any concerns being raised by patients or their families.

- We have continued to engage with our patient representatives and have engaged more widely with our community seeking opportunities for good dialogue with patients and members of the public. For example, we continue to have an active and engaged Patient Panel and patient representatives on most major sub-committees of the Board, and on many of our specialty groups. As a Foundation Trust we are developing our relationship and communications with our Governors and Members. We also held regular Members' Health Events during the year where our members have been invited to hear presentations

from a number of clinicians.

How did we perform in 2010/11?

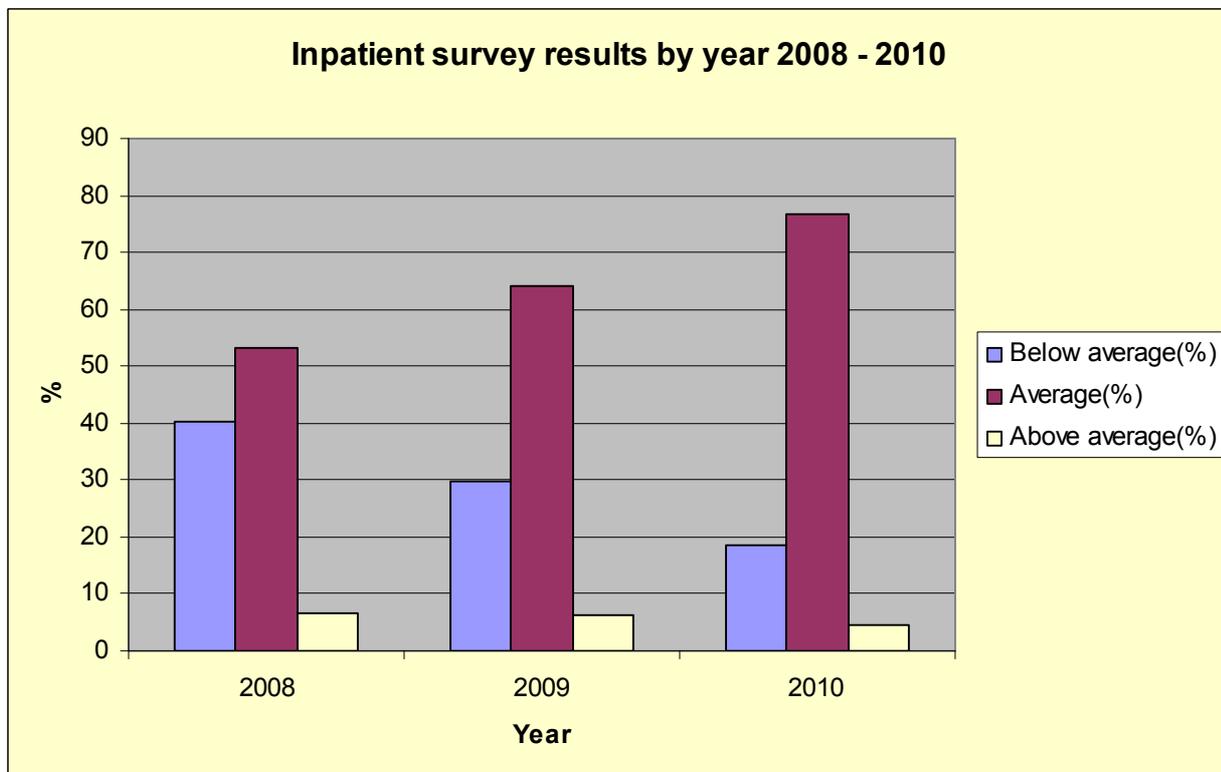
- Over the last year the Trust has seen a 10% reduction in both the number of formal and informal concerns raised by patients and their carers.

The Trust continues to welcome and respond to feedback it receives on the patient experience through concerns raised. All concerns are investigated and patients provided with a response which, where appropriate, will fully apologise for any failing in patients' care and explain what actions will be taken to prevent recurrence.

- Results from the National Inpatient survey indicate that patients value the opportunity to give feedback with the Trust assessed as being in the top 20% of organisations who, while in hospital, asked patients to give their views on the quality of their care.
- Overall, our patient survey results are showing an improvement and our performance has moved from the bottom 20% of Trusts (2009 survey) to the middle 60% of Trusts (2010 survey). Our ambition however is to be one of the best performing Trusts and we aim to be in the top 20% of Trusts by 2012/13.

The following graph shows our overall improvement in the national inpatient survey results over the last three years. The maroon bars demonstrate our improvement in the number of questions being scored as 'average', with the declining blue bars showing the number of 'below average' scores for the Trust.

Graph one: Graphical presentation of the % spread of Trust Inpatient survey scores by year: 2008 – 2010



Source CQC National Inpatient Survey Benchmark Reports: 2008, 2009, 2010

Priority 2 - Improving all aspects of communication with patients

Why is this a priority?

Good communication – both face to face and in terms of written information – makes a big difference to a patient's overall experience. A significant proportion of complaints that come into the Trust focus on communication issues and communication remains an area for continued focus and improvement.

Last year we set this as a key quality priority to be measured through the number of complaints resulting from poor communication and elements of the national patient survey.

What did we do in 2010/11?

- We have used our Trust values (the 4 Ps: *Patients First, Personal Responsibility, Passion for Excellence, Pride in our Team*) and behaviours to stress the importance of good communication, particularly around putting *Patients First*. Particular emphasis has been made on using phrases such as 'Is there anything else I can do for you?' and these have been reinforced through communication training and a number of staff focus groups. We have worked to embed these values and behaviours with staff and for 2011/12 are taking this a step further through a Trust-wide programme, '*Living our Values*'. This will use real patient stories, delivered by the patient to all the Trust's staff, to emphasise the impact an individual's behaviour (good or bad) can have on a patient.
- We have redrafted our standard first outpatient appointment letter to make it clearer for patients and developed an accompanying information leaflet (one for each hospital) setting out useful information such as how to get to hospital, where to go on arrival, how to park and so on. We piloted these new letters through ophthalmology and dermatology as these are both high volume outpatient specialties and are currently rolling the new letters out to all other specialties.
- Improved our patient information leaflets, making sure they are written in a clear and jargon free way and set out in an easy to read format and standard template. All departments across our two hospitals are being encouraged to review their written patient information to make sure it is current and up to date, produced in a professional way and made easily available to patients.
- Improved the way we communicate information about medicines to our patients, particularly when they are being discharged from hospital. This has included the introduction of a medicines hotline for patients to call when they arrive home and better printed information. Staff have also been trained in how to explain medicines to their patients when they leave hospital.
- Over the last three years the Trust has consistently been assessed as being in the top 20% of Trusts copying letters to patients between the hospital and the patient's family doctor. This continues to be important in ensuring that patients remain fully informed about their care.

How did we perform in 2010/11?

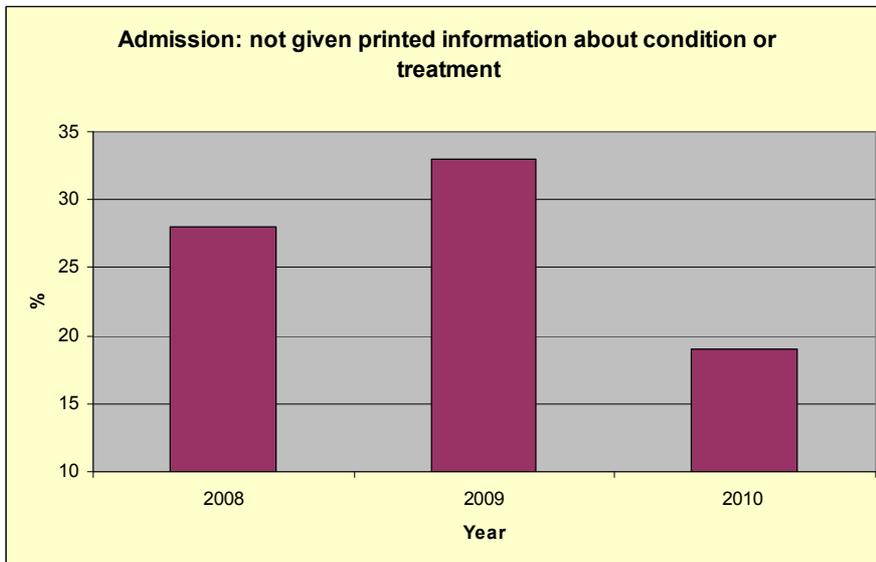
The following graphs demonstrate improvements made in communicating with our patients as shown in the results of last year's inpatient survey. When looking at the graphs it is important to note that **lower scores are better**.

Graphs two and three below indicate that we have improved the availability of information for our patients on their condition and treatment and on their medicines when they are discharged, with a lower number of patients reporting that they did not have enough information.

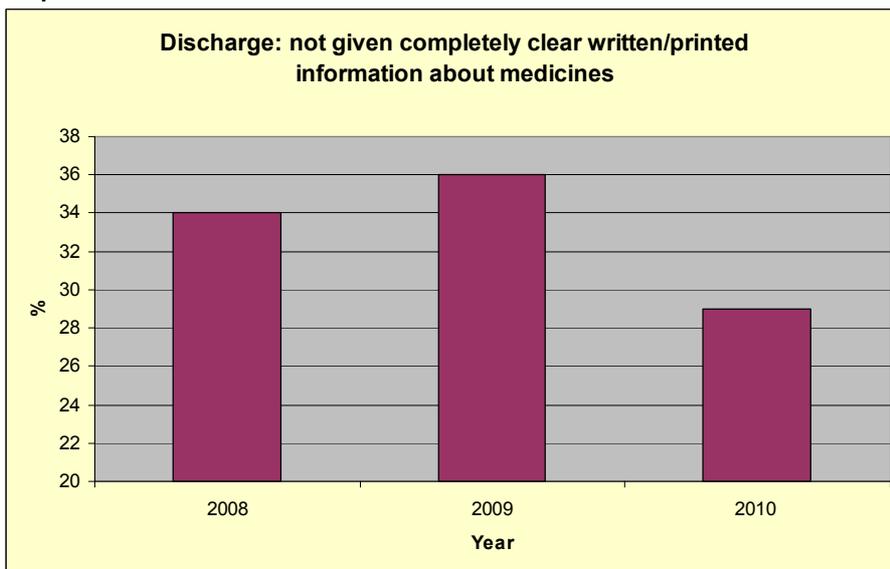
Graphs two and three: Trust 2010 Inpatient Survey Results demonstrating improvements in communication

Source: Picker Institute Europe Report. Note: Lower scores are better

Graph two:



Graph three:



Graphs four and five below indicate that our patients have more confidence in our nurses with a lower number of patients reporting that they did not have confidence. We believe an element of this improved confidence is due to better communication. Privacy is also an important element of good communication. Graph five indicates that the number of patients that report not having enough privacy has reduced.

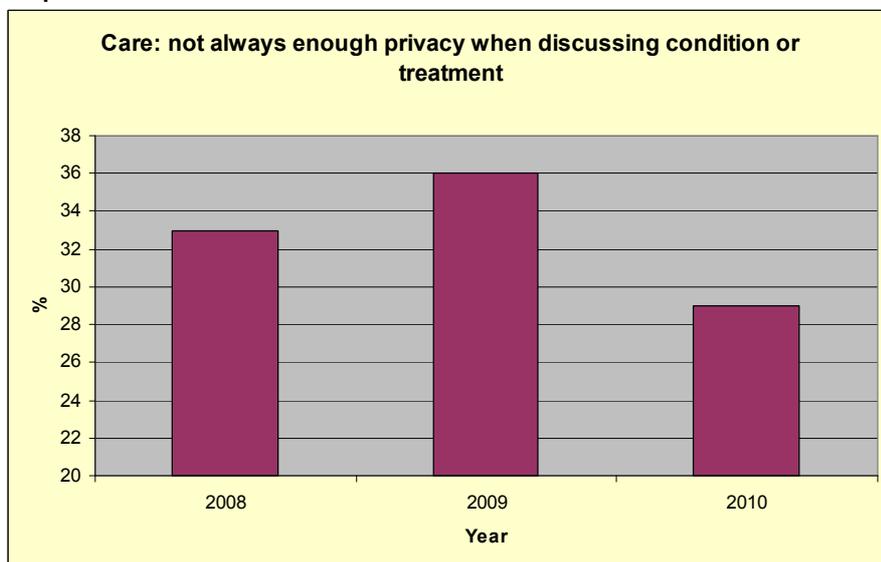
Graphs four and five: Trust 2010 Inpatient Survey Results demonstrating improvements in communication

Source: Picker Institute Europe Report. Note: Lower scores are better

Graph four:



Graph five:



Maintaining high safety standards

Our next two priorities for last year were set around maintaining high safety standards:

Priority 3 - Reducing hospital acquired infections

Why is this a priority?

It is vital that we do everything we can to reduce the likelihood of patients getting an infection whilst they are in hospital as a result of the care they receive. Although we have significantly reduced the levels of hospital acquired infections over the last few years, we are committed to reducing these even further.

Last year the Department of Health set us very tough infection control limits – no more than five hospital acquired cases of MRSA bacteraemia, and no more than 103 cases of clostridium difficile with a more stretching local limit (set by the Strategic Health Authority) of no more than of 67. We met both of these. The delivery of the MRSA limit represented a particularly significant achievement, but the reduction in the incidence of clostridium difficile, and the reduction in mortality associated with this condition was also a strong performance

What did we do in 2010/11?

Over the course of the year we undertook a number of key actions to continue to improve our infection control. These included:

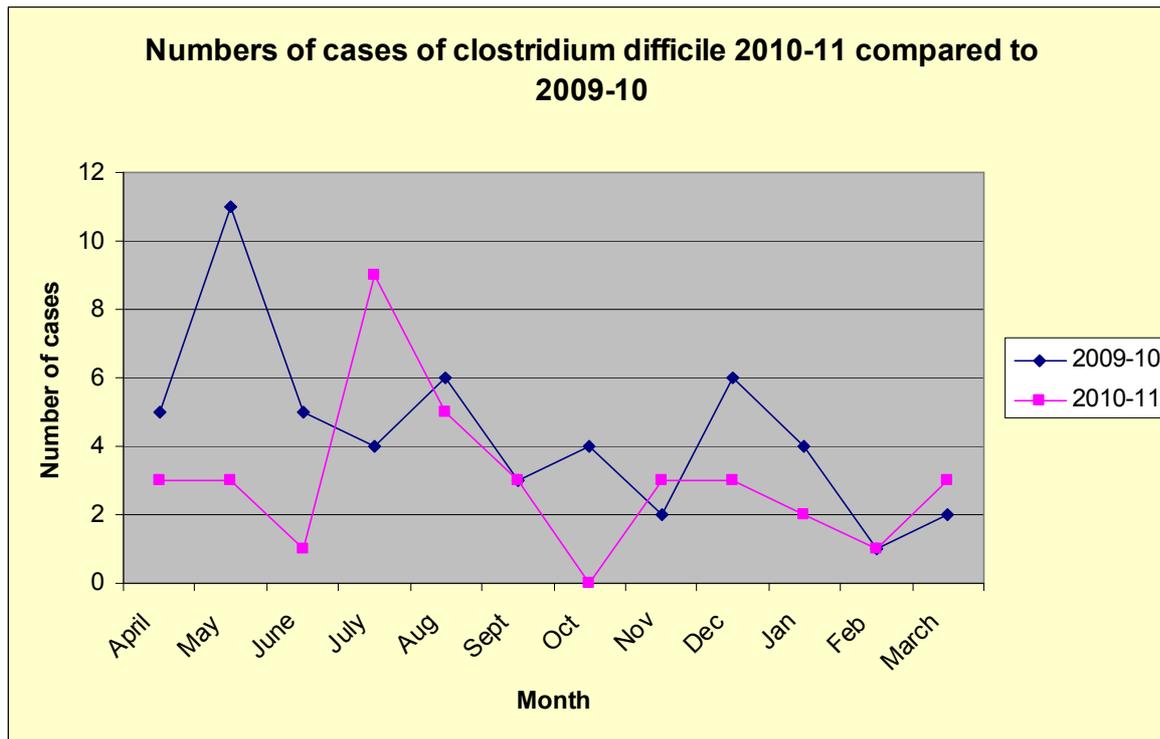
- Updating the Trust's policy for taking Blood Cultures.
- A mandatory requirement that a Consultant or Registrar sign off all blood culture requests.
- The development of a 24/7 blood culture taking service which meant that all cultures were taken by a highly trained member of staff.
- Introducing a standard that no member of staff is allowed, under any circumstance, to take blood cultures unless they had successfully completed specific training.
- Introducing urinary catheter packs with pre-connected catheters throughout the Trust.
- Screening all patients admitted to the Trust for MRSA, deferring admission of elective patients until treated and actively treating emergency patients who screened positive.
- Further review of antibiotic protocols, dosing and timings to help prevent post surgical site infections and reduce the risk of clostridium difficile.
- Further reinforcement of the importance of hand hygiene and our overall hygiene code (including bare below the elbow) and 6 monthly hand hygiene roadshows.

How did we perform in 2010/11?

By the end of the year our increased vigilance and focus meant that we did not exceed our infection control limits for either MRSA bacteraemia or clostridium difficile. During the year we also demonstrated an impressive 246 days MRSA free. Our MRSA limit for 2011/12 has been set at no more than 4 hospital acquired cases and our ongoing vigilance and focus on infection control will be essential.

Graph six below presents the Trust performance against our clostridium difficile limits. Again the Trust has performed well, reporting 36 hospital acquired cases for the whole year against our limit of no more than 67 cases

Graph six: Clostridium difficile cases



4. Reducing falls

Why is this a priority?

In helping patients recover while they are in hospital, particularly when they are regaining their independence, there will inevitably be some slips, trips and falls as patients regain their mobility. Our aim is to make sure that these are kept to an absolute minimum and that we do all we can to reduce harm to patients who do experience a fall. The measure we put in place to monitor our performance was the number of falls which resulted in harm.

What did we do in 2010/11?

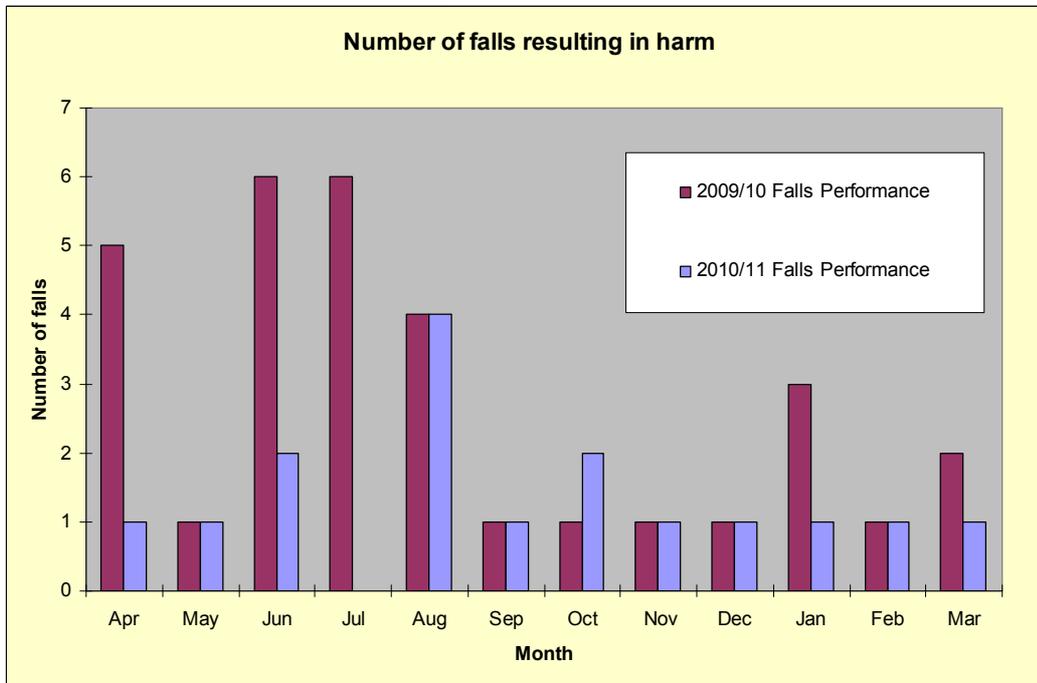
During 2010/11 we initiated a number of actions to reduce the number of falls resulting in harm across the Trust. This included identifying champions for prevention of falls, more carefully assessing patients at risk of a fall and analysing the cause of a patient fall as follows:

- Falls ‘champions’ identified on wards including Elm, Juniper, Kestrel and Maple with local responsibility for preventing falls.
- Following a successful pilot, the implementation of a ‘safety cross’ visually displaying on ward notice-boards the number of days that have passed since a patient fell so staff patients and visitors can see the results.
- A continuing project to revise and develop a falls risk assessment for all patients on admission. For those patients assessed at being most at risk, we are also developing a multi-disciplinary care plan to ensure they receive the most appropriate care.
- Development of an analysis tool aimed at understanding the ‘root cause’ of a patient fall.
- Analysis of falls data by ward to identify trends in falls for example, particular times of patient falls so that appropriate action can be taken. This may include carefully looking at and changing ward routines to minimise risk.

How did we perform in 2010/11?

In 2009/10 the Trust reported a total of 32 falls that resulted in harm. For 2010/11 we set ourselves a target of no more than 29 falls that resulted in harm. At the end of the year we had reported to the Trust Board a total of 16 falls that had resulted in harm; thus reducing the total number of falls resulting in harm by 50%. Our progress is demonstrated in Graph Seven below.

Graph seven: Number of falls resulting in harm



We believe that there is more to do to reduce the number of falls and injury from falls within our hospitals and this will continue to be one of our chosen quality priorities for this year 2011/12. Most recently, the Trust has appointed a Falls Coordinator who will work with staff to take this important preventative work forward.

Achieving high quality clinical care and effectiveness

We want to make sure that patients who come to Ashford and St Peter's Hospitals have the best possible clinical outcomes and last year we chose two targets to focus on where we knew improvements would make a big difference to our patients' recovery.

Priority 5 - Ensuring that patients with a fractured hip that are fit for undergoing surgery get their operation within 36 hours of admission

Why is this a priority?

Patients who come into hospital with a fractured hip will recover much more quickly, with better long-term results, the quicker they have their operation. Any delay in surgery for these patients can also increase the risk of death.

The Primary Care Trust set us a target to operate on 85% of patients within 36 hours of arriving in hospital and, over the last year, we have dramatically improved against this target. We are very proud of this achievement.

What did we do in 2010/11?

The Trust accepted that the Primary Care Trust target was important particularly because it reflected the quality of care we provided to this group of patients. All staff within the Orthopaedic Service fully accepted the clinical argument that early operative intervention would reduce hospital length of stay, reduce mortality and morbidity and improve patient experience. The Trust's performance review process identified and publicised the problem and analysed the underlying causes.

The Divisions of Acute Medicine, Theatres and Anaesthetics took joint responsibility for delivering a solution to this complex problem. Following initial cross divisional discussions, a multidisciplinary service improvement event with patient representation was held. This mapped the patient's journey and identified a number of "early quick win" interventions and some areas which needed further improvement events.

Over the year we have introduced a number of improvements to our patient pathway which have contributed to reducing the time taken for eligible patients to have their surgery. These include:

- The creation of an Orthogeriatric Service, offering rapid preoperative assessment of all patients presenting with fractured hip and a fast track service for optimisation of the patient's medical condition.
- Formation of an Orthopaedic Trauma Team highly skilled in this area of intervention and committed to provide a 24/7 service.
- Prioritising theatre time – moving patients up the priority list for surgery; introducing lists at weekends so patients who are brought in, for example on a Friday night, don't have to wait until Monday to have their operation.

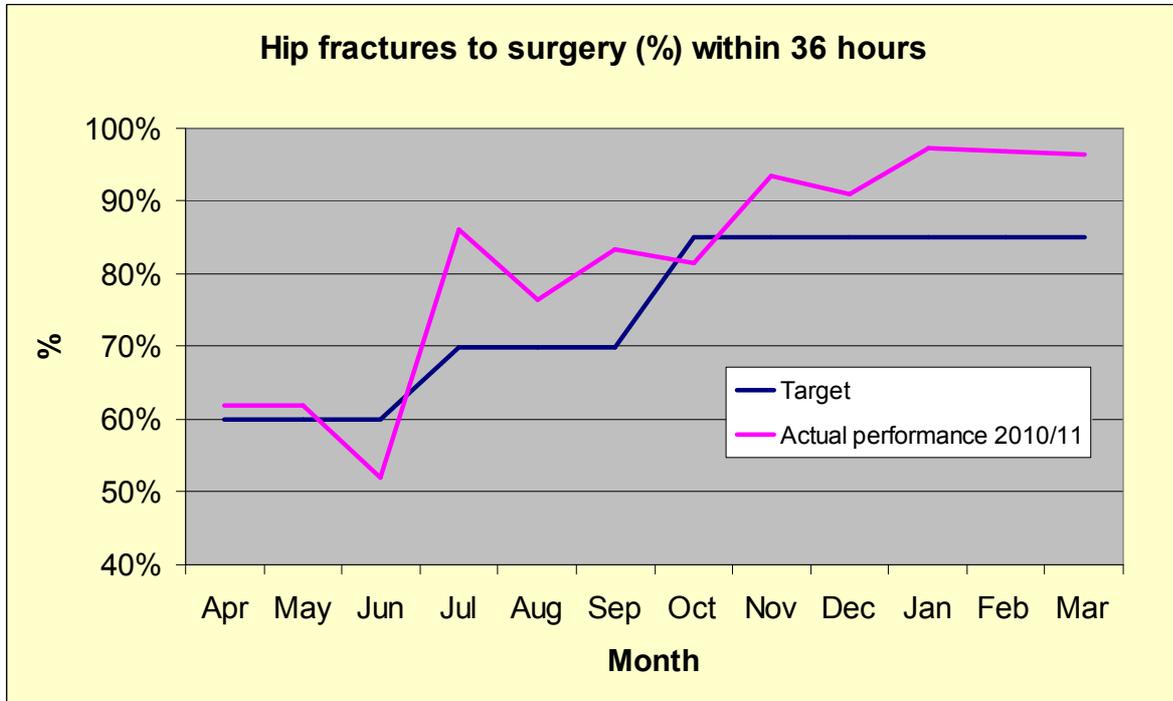
In addition, we are improving recovery and shortening these patients' length of stay in hospital by:

- Mobilising the majority of patients within 24 hours of their operation which we know improves their recovery.
- Providing physiotherapy 7 days a week.

How did we perform in 2010/11?

At the beginning of the year, just 52% of our hip fracture patients were operated on within 36 hours; by the end of the year this had risen to 93% and we are now one of the best performing Trusts in the country. Furthermore we are now operating on 75% of our patients within just 24 hours against our locally set target of 40%.

Graph eight: % of hip fracture patients to surgery within 36 hours



In addition, Trust data submitted to the National Hip Fracture Database (NHFD) indicates an improvement in the Trust's mortality rates for patients presenting with a fractured hip from 8.8% in 2009/10 to 6.4% in 2010/11. This compares favourably with a nationally reported mortality of 7.7% in 2009/10. Patients are also recovering more quickly and staying in hospital for an average of only 22.1 days in 2010/11 compared to 25.2 days in 2009/10. This compares with a nationally reported average of 25 days in 2009/10.

Priority 6 - Improving the effectiveness and efficiency of a patient hospital stay

Why is this a priority?

Most people want to stay in hospital for as short a time as possible and we know that patients recover better out of hospital and in their own surroundings. Reducing the amount of time a patient spends in hospital is about improving the whole quality of care – providing the best care first time, every time. In other words, reducing those things that can keep people in hospital longer than they need to be – complications like chest infections, reducing wasteful steps in our processes and reducing variations in the way we treat people with similar conditions.

What did we do in 2010/11?

Over the year we have taken a number of actions to improve the patient's quality of care and therefore reduce the time they spend in hospital. We have:

- Where possible, continued to undertake elective surgical procedures as day cases – we now undertake 83% of planned procedures as day case and last year were rated 7th best performing in the country for our day case rates.
- Increased the level of medical consultant presence in our assessment areas with consultants available from 7am in the morning to 8pm in the evening, seven days a week, undertaking ongoing reviews of all our emergency admissions.
- Engaged in service improvement events to reduce the amount of time patients spend in hospital and to improve patient pathways. Some of this work involves making sure we are doing the right things at the right time in the right place so patients are not waiting unnecessarily – for example for investigations to take place and treatment plans to commence.
- Introduced 'ward boards' which give much more visible detail about each patient's status on the ward so staff can make sure that the right actions are undertaken promptly thereby speeding up each patient's treatment.

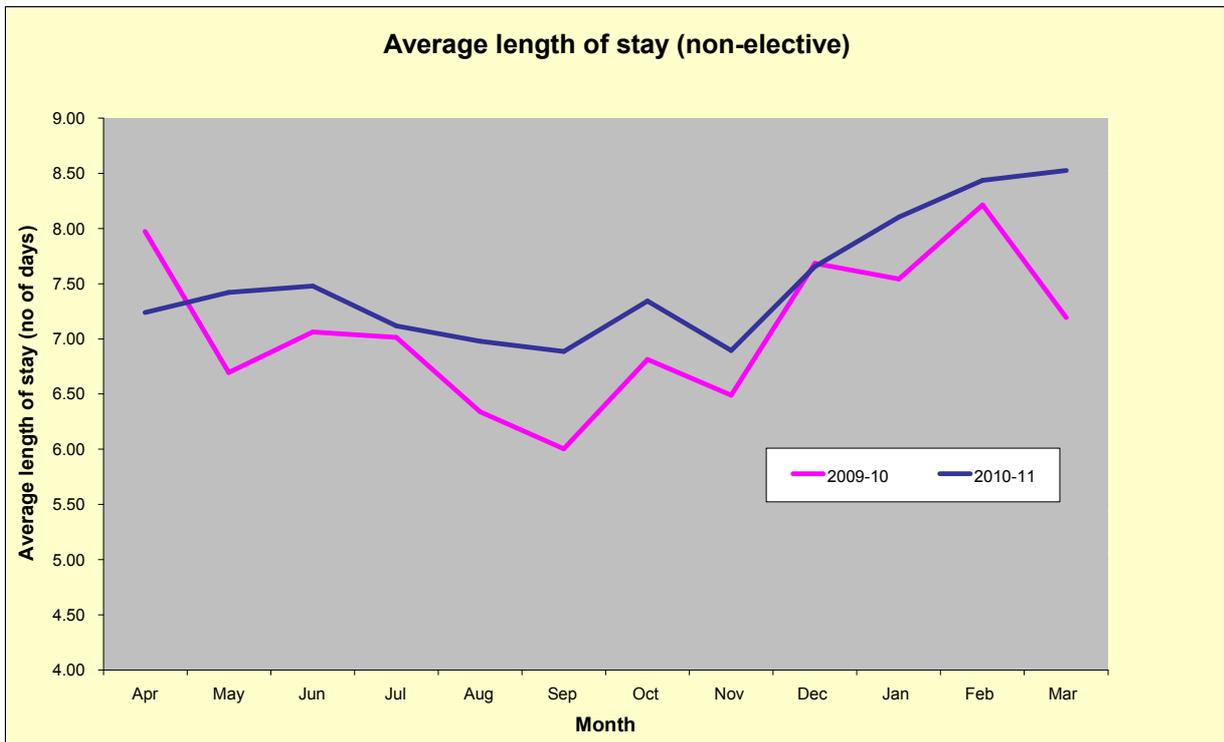
Most recently we have also brought together a team of people from across hospital disciplines to look critically at our processes for discharge and how we can make these more streamlined and effective. Not only are we aiming to improve the timeliness of the discharge but importantly, make the experience more positive for our patients.

How did we perform in 2010/11?

Although we continue to benchmark well against other Trusts, when looking at the average length of stay for both elective and non elective patients, the Trust has not made the progress that it hoped and, when compared with our 2009/10 figures, we have seen a slight increase in the average number of days non elective patients have stayed with us. (This is demonstrated in Graph nine below). This has been driven by a range of factors, some of which are internal and some external:

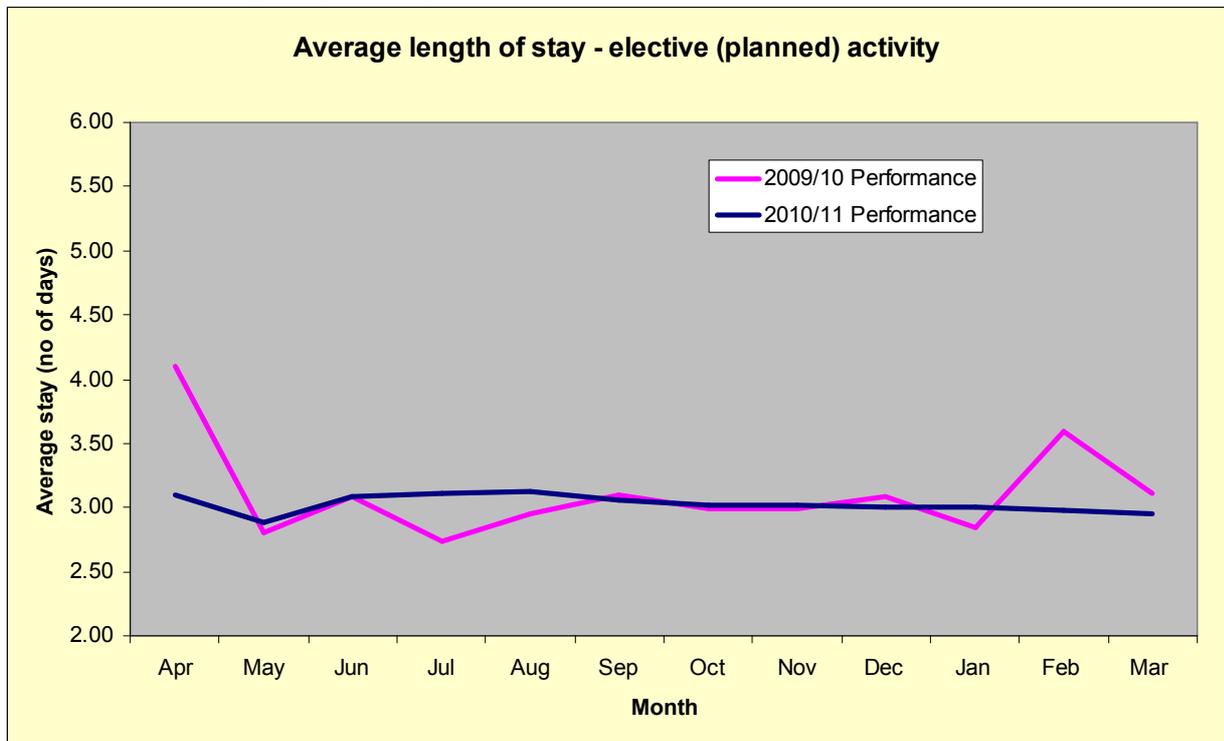
- A long and stretching winter with increased demand for emergency services and patients not always being accommodated in the right areas, which can decrease efficiency across the hospital.
- The availability of appropriate, home based support and services for a growing very elderly population with complex needs, which has increased the number of people waiting in hospital for the care they need to be arranged in the community.

Graph nine: The average length of stay for our non elective patients



However, the average length of stay for our elective patients (routine admission for planned surgery at a time convenient for the patient) has seen a slight reduction and finished the year on target. This can be seen in Graph ten.

Graph ten: The average length of stay for our elective patients



Our Priorities for Improvement for 2011/12

How our priorities were chosen

In drawing up our priorities for improvement for 2011/12 we have taken into consideration our progress against last year's priorities some of which are now secured as business as usual whilst others require continued focus. We have also considered the local, regional and national picture, our overall performance as well as the views of patients, our Governors, commissioners and patient representatives from our LINK and patient panel.

Following a process of engagement, including an afternoon of debate with representatives from our staff, Governors, LINKs and Patient Panel we identified seven key priorities for this coming year which we believe should be our focus in improving patient experience, safety and clinical outcomes. These priorities have been endorsed by the Trust Board.

Improving our Patient Experience

Priority 1 – To provide safe, high quality discharge for patients

Why have we chosen this priority?

Patients and their carers tell us that their experience of discharge from the Trust is not always as good as it should be. We also know that poor discharge practice can lead to preventable readmissions to the hospital.

How will we improve discharge?

A range of actions are already underway and will continue through the year, which include:

- A programme of discharge road-shows across the hospitals to reinforce the importance of good quality discharge to our staff.
- An improvement programme focussing on staff training, enabling ward staff to be more accountable for good and efficient discharge.
- Piloting telephone calls to patients to follow up on how they are doing the day after they have been discharged from hospital.
- Development of e-prescribing to speed up the dispensing of medicines for patients going home.
- Improving the operation of our Discharge Lounge to make sure we meet the needs of the patients and their families.

How will we measure our improvement?

We will monitor our overall patient experience of their care looking at the results from our "Your Feedback" questionnaires and the National Inpatient Survey.

We will measure improvement by monitoring the number of complaints received by the Trust that relate to discharge issues and practice and the patients reported experience of discharge through the results achieved in the National Inpatient Survey.

What will our target be?

- To reduce the number of patient concerns measured through formal complaints relating to discharge by 2013/14 as follows:

2011/12	30% (of the 2010/11 value)
2012/13	15% (of the 2011/12 value)
2013/14	15% (of the 2012/13 value)

In measuring this reduction, the Trust will use the total numbers of concerns recorded at the end of 2010/11 (87 concerns) as the baseline measurement

- To improve on the nationally benchmarked score of patient experience of discharge as reported through the Care Quality Commission report of the Trust's Inpatient survey results.

How will we monitor and report our improvement?

'Your Feedback' results will be reported quarterly to the Trust Board as part of the Trust's Quality Report. The Trust will be aiming for an improvement in the number of patients stating they would recommend the Trust to family and friends.

Complaints and concerns received regarding the discharge process will be reported quarterly at the Complaints Monitoring Group with progress noted against the targets set. Progress will also be reported to the Trust Board as part of the Trust's Quality Report.

The benchmarked Care Quality Commission report of the Trust's Inpatient survey results will be reported to the Trust Board with specific reference to those measures that look at patients' experience of discharge.

Priority 2 – To provide high quality experience relating to nutrition and hydration

Why have we chosen this priority?

Feeding our patients appropriately and making sure they have enough to drink is essential for all patients receiving care in the Trust. This is particularly important for our most vulnerable patients where this links to our ongoing work to provide high quality care for the vulnerable and elderly including those with dementia and who are at the end of their life.

How will we improve patient nutrition and hydration?

- Our 'Best Care' programme includes a dedicated workstream to improve nutrition and hydration.
- Our Lead Practitioner Nurse in Nutrition and Dietetics will complete regular audits to make sure patients are having the right food and enough to drink, and will work with ward staff and clinical areas to give additional support to those who need it most.
- We will re-launch our protected mealtimes for patients.
- Monthly audits of screening patients for malnutrition using the Malnutrition Universal Screening Tool. We will make sure our staff are fully trained in using this tool. This is important as early identification of any nutritional issues mean treatments, referrals and support can be initiated in a timely manner.
- We plan to hold a Nutrition Focus Month in June which will give all staff the opportunity to consider the importance of nutritional assessment and support and to reflect on their practice.

- We have introduced Care Rounds on our wards (where nursing staff check on patients on a regular, usually hourly basis) which will include making sure patients are having the right food and enough to drink.

How will we measure our improvement?

We will measure improvement through regular Essence of Care Nutritional Audits. Our work on nutrition will be monitored by the Nutrition Steering Group who in turn report to the Trust's Clinical Governance Committee.

What will our target be?

To improve the Essence of Care Nutritional Audit results by 10% against the baseline nutrition audit conducted in December 2010.

How will we monitor and report our improvement?

We will report the results of our Essence of Care Nutritional Audits and our progress against the agreed targets to the Trust Board quarterly as part of the Trust's Quality Report

Maintaining high safety standards

Priority 3 – To provide confidence and reassurance for patients on infection control, including MRSA and clostridium difficile as well as other preventable infections

Why have we chosen this priority?

Although the Trust has performed well in the reduction of hospital acquired infections, this remains a key indicator of clinical quality and patients continue to require assurance that a heavy emphasis on infection control persists.

How will we do this?

We will continue to build on our good practice and in particular we will focus on:

- Prevention of peripheral and central line acquired infections.
- Preventing urinary catheter acquired infections.
- Good infection controls and hand hygiene.

How will we measure our improvement?

While it is a Trust priority to eliminate all infections, we believe that the incidence of MRSA and clostridium difficile infections remain strong markers of good infection control. We will therefore record any incidence of an MRSA or clostridium difficile infection.

What will our target be?

- No more than 4 MRSA bacteraemia cases for 2011/12.
- No more than 33 cases of clostridium difficile for 2011/12.

How will we monitor and report our improvement?

Regular reports of the numbers of acquired infections will be made to our Clinical Governance Committee, Trust Executive Committee and the Board as part of our monthly Quality Report.

Priority 4 – To improve the quality of nursing care by setting and measuring a number of nursing sensitive indicators

Two key areas of focus will be the prevention of pressure ulcers and falls.

Why have we chosen this priority?

We know that sometimes our nursing care falls short of the very high standards our patients deserve. The incidence of pressure ulcers and falls are known to be credible indicators of nursing quality and also respond well to high quality nursing intervention. As our patient population becomes increasingly elderly and vulnerable we want to ensure that our nursing care meets their needs and promotes well being.

How will we do this?

- Implementation of the Best Care Programme and the High Impact Interventions for Nursing and Midwifery.
- Undertake staff training and development ensuring the use of best practice evidence based nursing care.
- Appointing a Lead Nurse for Falls Prevention.
- Ward level measurement and response to incidence of falls and pressure ulcers together with regional and national benchmarking.

- Targeted support from Tissue Viability Specialist Nurse.

How will we measure our improvement?

All incidence of falls and grade 2 or above hospital acquired pressure ulcers will be reported as part of the Trust's risk management processes and recorded on the Trust risk management database.

What will our target be?

- 10% reduction in falls that result in harm year on year.
- Overall a 10% reduction in all reported falls year on year.
- 5% reduction in grade 2 or above hospital acquired pressure ulcers year on year.

How will we monitor and report our improvement?

We will monitor these indicators at ward level via the Ward Quality Indicators which are reported to the Board monthly. The incidence of falls and grade 2 or above hospital acquired pressure ulcers will also be monitored at the Trust Safety and Risk Committee and also reported to the Trust Board.

Achieving high quality clinical care

Priority 5 – To reduce the hospital emergency and elective readmission rate

Why have we chosen this priority?

It is important for patients to have the most effective care that leads to discharge in a timely and safe manner with the required support to avoid readmissions to hospital within 30 days of discharge.

How will we do this?

- Ensuring that care and treatment is of high quality and that we drive reductions in preventable harm or complications that can lead to readmissions.
- Implementing a programme to improve discharge.
- we will continue our 'Experience Based Design' project where we work with patients and Community staff to understand why they need to come back into hospital after they have been discharged.
- Operating a 'Virtual Ward' – where patients who still need some additional care once they are discharged from hospital receive this in the community by visits several times a day by community staff.

How will we measure our improvement?

We will measure our improvements against agreed targets.

What will our target be?

Reduction in readmissions following an elective procedure within 28 days of discharge by 2013/14 as follows:

- 2011/12 50% (of the 2010/11 value)
- 2012/13 25% (of the 2011/12 value)
- 2013/14 15% (of the 2012/13 value)

In measuring this reduction, the Trust will use the total number of elective readmissions recorded at the end of 2010/11 (976 readmissions) as the baseline measurement

Reduction in readmissions following an emergency admission within 28 days of discharge by 2013/14 as follows:

- 2011/12 15% (of the 2010/11 value)
- 2012/13 10% (of the 2011/12 value)
- 2013/14 5% (of the 2012/13 value)

In measuring this reduction, the Trust will use the total number of non elective readmissions recorded at the end of 2010/11 (3711 readmissions) as the baseline measurement

How will we monitor and report our improvement?

Readmission rates are included on our monthly quality report to the Trust Board.

Priority 6 – To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure

Why have we chosen this priority?

The Trust is actively participating in a national programme - The Enhancing Quality (EQ) Programme - to improve care and reduce the number of deaths of patients with pneumonia and heart failure; common cardiovascular and respiratory conditions.

How will we do this?

The Trust's EQ Programme is guiding improvement work on these key, high volume, pathways with its objective to reduce readmission rates, complication rates with improved patient experience and outcomes.

How will we measure our improvement?

The EQ Programme has continuous data collection with improvement targets and milestones set (by the Strategic Health Authority) to allow the Trust to benchmark its performance nationally. Data submissions are monitored on a monthly basis and reported via the EQ Steering Group. The Trust will be reporting Crude (CMR) and Standardised Mortality Rates (SMR) for pneumonia and heart failure patients.

What will our target be?

- Reduction of 5% SMR for Heart Failure by 2013/14
- Reduction for hospital acquired Pneumonia of 1% SMR year on year

How will we monitor and report our improvement?

Information will be collected monthly and reported to:

- Trust Clinical Effectiveness and Audit Group (which meets every 6 – 8 weeks).
- To Trust Board through the Monthly Quality report.

Priority 7 – To improve the experience and clinical outcomes for those with long term conditions by improving outpatient management and collaborative working with primary and community services

Why have we chosen this priority?

On average, 250 patients per day attend the A&E Department. Approximately 20% are admitted and are treated in the emergency inpatient setting. There is evidence to suggest that this is not the best way to treat patients with a long term condition. In order to improve the experience and outcomes for these patients the Trust, in partnership with colleagues in the community, has made it a priority to develop better pathways of care for these patients. The Trust has recently won designation as Surrey's Asthma Centre and, as a centre of excellence our aim is to deliver the best care based on the evidence available and to be able to publish improved outcomes.

How will we do this?

The Trust will, with NHS Surrey and Surrey Community Health, develop a better understanding of our treatment of patients with the most common conditions coming into hospital and compare this information with national data to identify areas for improvement. We will then develop and implement a series of care pathways for these conditions. Part of the service improvement will include development of the care delivered in the community and the Trust. It will also include launching 'expert patient' programmes to promote and sustain self management and an improved discharge process to prevent readmission.

How will we measure our improvement?

We will do this through our rates of attendance and subsequent admission for those patients in a selected high volume pathway. We have chosen COPD (Chronic Obstructive Pulmonary Disease) for this purpose.

What will our target be?

- To reduce our admission rate for COPD by 2.5% by Mar 2012.

How will we monitor and report our improvement?

Progress will be monitored by the Emergency Services and Acute Medicine Division and reported to Trust Board through the Monthly Quality report.

STATEMENTS OF ASSURANCE

These statements of assurance follow the statutory requirements for the presentation of Quality Accounts, as set out in the Department of Health's Quality Accounts regulations.

Review of services

Between April 2010 and March 2011 Ashford and St Peter's Hospitals NHS Foundation Trust provided and/or subcontracted 19 NHS services.

Ashford and St Peter's Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 19 of these NHS services

The income generated by the NHS services reviewed in 2010/2011 represents 100% of the total income generated from the provision of NHS services by Ashford and St Peter's Hospitals NHS Trust for 2010/2011.

Participation in clinical audit and review

Clinical audit is a simple tool to review clinical practice against best evidence standards identifying actions to improve the quality of patient care and treatment.

National confidential enquiry is a form of national clinical audit looking at potentially avoidable factors associated with poor outcomes.

During 2010/11 (48) national clinical audits and (6) national confidential enquiries covered NHS services that Ashford and St Peter's Hospitals NHS Foundation Trust provides.

During 2010/11 Ashford and St Peter's Hospitals NHS Foundation Trust participated in (79%) of the national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Ashford and St Peter's Hospitals NHS Foundation Trust was eligible to participate in during 2010/2011 and those that the Trust participated in are identified in the tables below.

These tables also contain details of the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

It can be seen from the following evidence that the Trust is undertaking all relevant national audits and has an active programme of local audits to support improvements in the quality of patient care.

Table 1: National Clinical Audits – continuous with no planned end date

Topic	Eligible to participate	Participated	%cases submitted
Neonatal intensive and special care (NNAP)	Yes	Yes	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	Yes	100%
Adult critical care (Case Mix Programme)	Yes	Yes	100%
Potential donor audit (NHS Blood & Transplant)	Yes	Yes	100%

Diabetes (National Adult Diabetes Audit)	Yes	Yes	100%
Hip, knee and ankle replacements (National Joint Registry)	Yes	Yes	100%
National Elective Surgery PROMs: Hip Replacements	Yes	Yes	80% ¹
National Elective Surgery PROMs: Knee Replacements	Yes	Yes	69% ¹
National Elective Surgery PROMs: Groin Hernias	Yes	Yes	65% ¹
National Elective Surgery PROMs: Varicose Veins	Yes	Yes	23% ¹
Coronary angioplasty (NICOR Adult cardiac interventions)	Yes	Yes	100%
Peripheral vascular surgery (VSGBI Surgery Database)	Yes	Yes	80%
Carotid interventions (Carotid Intervention Audit)	Yes	Yes	100%
Acute Myocardial Infarction & other ACS (MINAP)	Yes	Yes	60%
STEMI (ST Elevated MI)			100%
Heart failure (Heart Failure Audit)	Yes	No ²	
Acute stroke (SINAP)	Yes	Yes	60%
Hip fracture (National Hip Fracture Database)	Yes	Yes	100%
Severe trauma (Trauma Audit & Research Network)	Yes	Yes	64%
Lung cancer (National Lung Cancer Audit)	Yes	Yes	100%
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	Yes	100%
Head & neck cancer (DAHNO)	Yes	Yes	N/A ³
Pulmonary hypertension (Pulmonary Hypertension Audit)	Yes	N/A ⁴	N/A
Renal replacement therapy (Renal Registry)	Yes	Yes	N/A ⁵
Renal transplantation (NHSBT UK Transplant Registry)	Yes	Yes	N/A ⁵
Paediatric intensive care (PICANet)	No	N/A	N/A
Paediatric cardiac surgery (NICOR)	No	N/A	N/A
Cardiothoracic transplantation (NHSBT UK Transplant Registry)	No	N/A	N/A
Liver transplantation (NHSBT UK Transplant Registry)	No	N/A	N/A
CABG and valvular surgery (Adult cardiac surgery audit)	No	N/A	N/A

Notes: For some submissions reports are not yet available; we consider that we have identified all eligible patients

1. Participation from April 09 to November 10 (pre-operative questionnaires); these rates are an estimate of the true rate (<http://www.hesonline.nhs.uk/>).
2. Heart Failure: planning continues as there are issues relating to capture of the data and linking to the national database.
3. Head and Neck cancer data is submitted jointly through the Royal Surrey County Hospital Foundation Trust.
4. Pulmonary Hypertension: Trust patients will be included in this audit via designated Pulmonary Hypertension Services in London hospitals
5. ASPH patients are included in submissions via the renal unit at Epsom & St. Helier University Hospitals NHS Trust

Table 2: National Clinical Audits – intermittent (samples recruited according to time period or sample size; one-off, with no plan to repeat patient recruitment in the future)

Topic	Eligible to participate	Participated	%cases submitted
Paediatric pneumonia (British Thoracic Society)	Yes	No*	
Paediatric asthma (British Thoracic Society)	Yes	No*	
Paediatric fever (College of Emergency Medicine)	Yes	Yes	100%
Paediatric epilepsy (RCPH National Childhood Epilepsy)	Yes	Yes	N/A ¹
Emergency use of oxygen (British Thoracic Society)	Yes	Yes	100%
Adult community acquired pneumonia (British Thoracic Society)	Yes	No*	

Non invasive ventilation (NIV) - adults (British Thoracic Society)	Yes	No*	
Pleural procedures (British Thoracic Society)	Yes	Yes	N/C
Cardiac arrest (National Cardiac Arrest Audit)	Yes	Yes	N/A ¹
Vital signs in majors (College of Emergency Medicine)	Yes	Yes	100%
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	Yes	N/A ²
Chronic pain (National Pain Audit)	Yes	Yes	N/A ¹
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes	No*	
Parkinson's disease (National Parkinson's Audit)	Yes	Yes	100%
COPD (British Thoracic Society/European Audit)	Yes	Yes	N/C
Adult asthma (British Thoracic Society)	Yes	No*	
Bronchiectasis (British Thoracic Society)	Yes	No*	
Familial hypercholesterolaemia (National Clinical Audit of Management of FH)	Yes	No ³	
Stroke care (National Sentinel Stroke Audit)	Yes	Yes	117% ⁴
Renal colic (College of Emergency Medicine)	Yes	Yes	100%
Falls and non-hip fractures (National Falls & Bone Health Audit)	Yes	Yes	100%
O neg blood use (National Comparative Audit of Blood Transfusion)	Yes	Yes	100%
Platelet use (National Comparative Audit of Blood Transfusion)	Yes	Yes	100%
Patient transport (National Kidney Care Audit)	Yes	Yes	N/A ⁵
Depression & anxiety (National Audit of Psychological Therapies)	No	N/A	N/A
Prescribing in mental health services (POMH)	No	N/A	N/A
National Audit of Schizophrenia (NAS)	No	N/A	N/A

Notes:

*Non-participation for these national audits is due to lack of resources to undertake the work.

N/C (Not Confirmed) - data submitted but participation rates not confirmed.

For some submissions, reports are not yet available; we consider that we have identified all eligible patients.

1. Paediatric epilepsy, Cardiac arrest, Chronic pain audits: the Trust is registered to participate, data submission has not started
2. Heavy menstrual bleeding audit – data collection period runs from 01.02.11 to 31.01.12; the Trust has started data collection.
3. Familial hypercholesterolaemia: the Trust does not run outpatient clinics specifically for the condition and cannot identify these patients
4. 60 cases were required but 70 cases were returned and included in the audit.
5. ASPH patients are included in submissions via the renal unit at Epsom & St. Helier University Hospitals NHS Trust

Table 3: National Confidential Enquiries

Topic	Eligible to participate	Participated	%cases submitted
CEMACE Perinatal mortality	Yes	Yes	100%
NCEPOD Parenteral Nutrition Study	Yes	Yes	73%
NCEPOD Surgery in the Elderly	Yes	Yes	88%
NCEPOD Paediatric Surgery Study	Yes	Yes	100% ¹
NCEPOD Peri-operative Care Study	Yes	Yes	100%
NCEPOD Cardiac Arrest Procedures	Yes	Yes	- ²

NCEPOD Cosmetic Surgery Study	No	N/A	N/A
CISH (suicide and homicide by people with mental illness)	No	N/A	N/A

Notes: 1. We fully participated in the study; our submissions were that we had no paediatric cases which met the criteria for the study.
2. Data collection for this study is ongoing.

National and local clinical audits reviewed

The reports of 8 national clinical audits were reviewed by Ashford and St Peter's Hospitals NHS Foundation Trust in 2010/2011 and as a result the Trust intends to take actions to improve quality of care.

Audit Report	Areas of action
National Audit of Continence Care	New Best Care nursing programme with workstreams of essential and specialist care led by the Deputy Chief Nurse with Heads of Nursing and Matrons.
National Dementia Care Audit	Dementia Steering Group leading on: <ul style="list-style-type: none"> • Development of a dementia strategy • Introduction of new procedures and guidelines • Provision of training for staff in special aspects of care for patients with dementia.
National Sentinel Stroke Audit	The Stroke team is working to increase the number of patients experiencing all the best practice interventions and improving: <ul style="list-style-type: none"> • Screening and function assessment after admission • Promotion of continence care • Communications with patients and carers
Use of Emergency Oxygen in Adult Patients	<ul style="list-style-type: none"> • Training of all nurses and healthcare assistants joining the Trust and training on the use of devices as part of acute skills day • Further training for pharmacy staff with the aim of increasing oxygen prescription rates • Involvement of the acute pain team in the prescription of oxygen for patients with epidurals and patient controlled analgesia
NCEPOD Deaths in Acute Hospital	<ul style="list-style-type: none"> • Revision of junior staff rota to improve continuity of care • Improvements to the communication of critical radiological findings • Development of a 7/7 radiology service linking with St George's Healthcare NHS Trust
NCEPOD Surgery in the Elderly	<ul style="list-style-type: none"> • Junior doctor training during their educational programme and via online training relating to: <ul style="list-style-type: none"> ○ Acute kidney injury ○ Abdominal symptoms

	<ul style="list-style-type: none"> ○ Pain as the 5th vital sign ○ Assessment of malnutrition status ● Continued training for frontline A&E staff
NCEPOD Parenteral Nutrition Care	<ul style="list-style-type: none"> ● New lead nutrition nurse undertaking educational sessions with nursing staff ● Development of online compulsory training for junior doctors ● Review of the parenteral nutrition policy and changes to the parenteral nutrition prescription form ● Production of a neonatal guideline ● Nutrition focus month in June 2011
PROMs: hip and knee replacement, groin hernia and varicose vein operations	Practice is within the national range for these procedures. Actions for hip and knee surgery include ensuring that all patients receive antibiotic prophylaxis within one hour prior to surgery.

The reports of 73 local clinical audits were reviewed by Ashford and St Peter's Hospitals NHS Foundation Trust 2010/2011 and actions have been taken to improve the quality of healthcare provided. Results from these clinical audits were presented within specialties and included in reports to the Clinical Effectiveness and Audit Group. Learning from the audits was shared across departments during educational meetings and included in the bimonthly audit newsletter. All issues which were considered to be urgent were addressed by the areas immediately and progress reported directly to the Clinical Governance Committee.

Some common areas of action from our local audits were:

- Review and updates to policies, procedures and guidelines;
- Review and streamlining of patient pathways to reduce delays;
- Focus on improving the documentation of patient care: in medical records, nursing care plans, discharge plans and communication with other NHS partners;
- Review of information provided to patients e.g. patient leaflets, hospital admission packs;
- Introduction of management walkabouts to observe patient care in action, routine care rounds to enable wards to tailor their approach and meet individual patient needs and essential care spot-checks;
- Reducing unnecessary admissions by working on a joint project with Surrey Community Health to assess patients on arrival to A&E;
- Additional training sessions for staff on a variety of topics (nutritional needs, dementia care, palliative care, administration of medicines, male catheterisation, wound management, cardiology, maxillofacial, safeguarding, breast care, infection control, respiratory medicine).

Participation in clinical research

Research enables NHS organisations to improve the current and future health of their patients and is an important element in driving quality improvements. Highlighting our support for clinical research our Chief Executive, Andrew Liles, has been elected as the new Chair of the Surrey and Sussex Local Research Network. The number of patients receiving NHS services provided or sub-contracted by Ashford and St Peter's Hospitals NHS Foundation Trust in 2010/2011 that were recruited during that period to participate in research approved by a research and development committee was 556, more than double that of 2009/10 (215).

Care Quality Commission (CQC) Registration

The Trust received an unconditional registration on 1st April 2010 by the new Care Quality Commission in recognition of our high quality services. We have continued to provide safe, quality services to our patients with good clinical outcomes and continued low mortality rates. The Care Quality Commission has not taken enforcement action against Ashford and St Peter's Hospitals NHS Foundation Trust during 2010/11 nor has the Trust participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion (up to 1.5% which equates to £2.9m) of Ashford and St Peter's Hospitals NHS Foundation Trust's income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between the Trust and NHS Surrey as lead commissioner through the 'Commissioning for Quality and Innovation payment framework (CQUIN)'.

Incentive payments through CQUIN helps to reinforce quality as a driving factor for NHS services and means that quality issues are at the heart of discussions between providers and their commissioners. The Trust worked with NHS Surrey to agree which quality measures would be measured through CQUIN for 2010/11 and these are listed below:

- To reduce avoidable death, disability and chronic ill health from venous thrombo-embolism
- To improve the way the Trust responds to patients' personal needs
- To improve patient safety by implementing electronic discharge summaries
- To encourage patients to stop smoking before their operations
- To screen women (under the age of 25 years) attending maternity services for chlamydia, as part of NHS Surrey's screening programme
- Improve data and the way we notify GPs of patients attending A&E with alcohol related diagnosis
- To improve quality through the regional Enhancing Quality programme which will measure our results in terms of patient care and treatment for five specific clinical conditions:
 - Heart attacks
 - Heart failure
 - Pneumonia
 - Hip replacements
 - Knee replacements
 -

During 2010/11 the Trust achieved 87.7% of our CQUIN target which equates to £2.5m.

Further details of the agreed goals for 2010/11 and for the following 12 month period are available on request from the Business Development Team, c/o St Peter's Hospital, Guildford Rd, Chertsey, KT16 0PZ or via the Trust website at www.ashfordstpeters.nhs.uk

Data Quality

Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. "We can only be sure to improve what we can actually measure," Lord Darzi, *High Quality Care for All*, June 2008.

General medical practice codes and NHS numbers

Ashford and St Peter's Hospitals NHS Foundation Trust submitted records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the

latest published data. The percentage of valid general medical practice codes and NHS numbers are shown in Table 2 below and reports a decrease in the use of the NHS number for A&E patients. A new national Personal Demographics Service (PDS) was implemented approximately 18 months ago. As a result of this change, the Trust experienced some technical difficulties with completing the NHS number verification process. These difficulties were resolved in November 2010 and since that time the Trust has been undertaking a comprehensive revalidation process. On a day to day basis, the Data Quality Team is reviewing A&E patient data in real time to ensure a valid NHS number is assigned.

Table 2: Percentage of valid general medical practice codes and NHS numbers

	2009/10			2010/11		
	Inpatients	A&E	Outpatients	Inpatients	A&E	Outpatients
General Medical Practice Code	100%	99.93%	99.74%	100%	99.76%	99.66%
NHS Number	99.21%	95.50%	99.15%	98.06%	90.45%	98.34%

General Medical Practice Code – the code given nationally to each practising GP

NHS Number – NHS numbers link patients to the treatment they have received and are unique to the patient

Information Governance Assessment

Ashford and St Peter's Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2010/11 was 71% and was graded Green.

Clinical Coding

Clinical coders translate the medical terminology written by clinicians into a standard (international) code to describe a patient's diagnosis and treatment. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records and also contributes to costing and monitoring hospital activity and performance.

Ashford & St Peter's Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2010-11 carried out by the Audit Commission due to high accuracy rates achieved in previous years' audits.

Further information about the Payment by Result Data Assurance Framework clinical coding audit is available from the Audit Commission.

The quality of coded data is internally monitored through regular Information Governance Clinical Coding Audits. Accuracy figures for the 2009-10 IG audit were:

	March 2010	September 2010
Primary diagnosis correct	94.00%	91.50%
Secondary diagnoses correct	88.17%	92.04%
Primary procedure correct	96.67%	92.81%
Secondary procedures correct	95.33%	93.59%

Ongoing actions to improve data quality include:

- Sharing of local activity data with consultants and divisional managers in order to increase their involvement in the collection, validation and use of coded data.
- Clinical coders continuing to be situated within ward areas in order to facilitate access to clinical teams and consultants.

- Regular training and education sessions being carried out for junior medical staff to provide a better understanding of how clinical information is collected and the importance of their contribution towards well documented source information supporting the coding process.
- Carrying out an internal quarterly audit of data quality
- Participating in an external annual audit of data quality

Further performance information

The following table outlines our performance during 2010/11 against indicators we have chosen for 2010/11 for patient safety, clinical effectiveness and patient experience. These also include locally agreed targets that have been set by NHS Surrey.

Locally agreed targets & Source of Data	Performance	09/10 actual (if available)	10/11 targets	10/11 actual	11/12 plan	Benchmark Comments
Patient safety						
Standardised mortality (Relative Risk)* <i>Dr Foster</i>		89.8	82	89.4	82	National peer group benchmark by Dr Foster. The Trust has a slightly higher crude mortality rate compared to the South East Coast average but we have a lower than average risk adjusted mortality (this means our rates are good)
Crude mortality <i>PAS</i>		Data unavailable	2.60%	1.60%	1.60%	
MRSA (Hospital only) <i>ASPH weekly HCAI Reporting</i>		9	5	5	4	Trusts across South East Coast have differing thresholds (ranging from 2 - 5) based on continual improvements and case-mix.
C.Difficile <i>ASPH weekly HCAI Reporting</i>		53	67	36	33	Trusts across South East Coast have differing thresholds (ranging from 25 - 70) based on continual improvements
SUIs (Serious Untoward Incidents) <i>Quality Department - Clinical Risk Manager</i>		Data unavailable	14	14	14	
SUI - root cause analysis within 60 Days* <i>Quality Department - Clinical Risk Manager</i>		100%	N/A (no threshold agreed with the PCT)	100%	100%	Note: The National Reporting Framework for Reporting and Learning from Serious Incidents suggest 45 days. The Trust will be monitoring against this standard in 2011/12.

Locally agreed targets & Source of Data	Performance	09/10 actual (if available)	10/11 targets	10/11 actual	11/12 plan	Benchmark Comments
Clinical effectiveness						
Falls in hospital - resulting in significant injury (grade 3) <i>Quality Department – Patient Safety Administrator</i>		32	29	16	14	ASPH fall rates were higher than the South East Coast SHA rates. The Trust was in the bottom quartile for performance (9/12 Trusts).
Hip fractures treated within 36 hrs <i>PAS and Orthopaedic Trauma Nurse Practitioner validations</i>		83.6% within 48hrs	85.00%	93.00%	85.00%	Comparative data is only available for treatment within 48hrs. ASPH ranked 2 nd out of the 10 Trusts in South East Coast that submitted data.
Emergency readmissions within 14 days <i>PAS</i>		2.90%	3.70%	3.50%	The Trust will undertake a new measure at 28 days	The Trust performance was 3.5% which is below the England average of 5.5%. The Trust was ranked at 55 out of 164 Trusts.
VTE Assessment <i>In Patient List System (IPL details)</i>		N/A	90.00%	85.20%	90.00%	The Trust demonstrated the 2 nd best performance of the South East Coast SHA Trusts (12), assessing over 90% of patients against a South East Coast SHA average of 52.9% and a national average of 68.4%.
A&E Attendances Resulting In Admission* <i>PAS - Ardentia SQL data warehouse</i>		20.90%	23.45%	22.14%	Awaiting confirmation from the PCT	Admission rates in A&E across the South East Coast SHA varied from 17.67% to 35.55%. The Trust admission rate was 23.25% ranking at 6 out of 11 Trusts that admit patients. (Benchmarking used Q4 data)
Pressure Ulcers* <i>Matron's ward quality indicators data submission.</i>		160	153	108	Standard not being measured by the PCT	The Trust incidence of pressure ulcers was generally lower than the average South East Coast SHA rates for 10/11. The Trust ranked 2 nd out of 12 Trusts in South East Coast.
Access to midwifery/Maternity services <i>Clinical Midwifery Manager, Community & Outpatients - Monthly booking report</i>		86.30%	80.00%	89.30%	90%	The Trust performance of 89.3% was above the South East Coast SHA average of 66.2% and a national average 65.6%. We rank 6/12 within South East Coast.
Caesarean Section Rate* <i>Maternity Systems & Coding Administrator weekly and monthly reporting</i>		27.70%	25.00%	25.90%	23%	NHS comparators: SHA Average is 24.5% National: Average is 23.9% (Spread across South East Coast is from 20 - 30%)

Locally agreed targets & Source of Data	Performance	09/10 actual (if available)	10/11 targets	10/11 actual	11/12 plan	Benchmark Comments
Patient experience						
Patient Satisfaction – Net Promoter Score <i>Net Promoter Score from 'Your feedback' data collection</i>			90.00%	77.30%	90.00%	
Formal complaints <i>Complaints Manager</i>		401	361	360	320	
Complaints - % Actioned within 25 Days* <i>PA / Complaints Team Co-ordinator</i>		98.36%	100.00%	96.75%	New standard for 2011/12	

* Primary Care Trust Targets

The following table outlines our performance against key national priorities contained within the Monitor Compliance Framework and other key Care Quality Commission indicators.

Performance against key national priorities 2010/11 & Source of data	Performance	09/10 actual (if available)	10/11 targets	10/11 actual	11/12 plan
A four-hour maximum wait in A&E from arrival to admission, transfer or discharge <i>AE_CSEUR - A&E daily siterep database.</i>		98.89%	95.00%	97.65%	<=4hrs
A maximum two-week wait standard for Rapid Access Chest Pain Clinics. <i>Cardiology - PRISM system monthly reporting</i>			98.00%	100.00%	Not applicable Not a national priority for 11/12
Thrombolysis 'call to needle' of at least 68 per cent within 60 minutes, where thrombolysis is the preferred local treatment for heart attack. <i>Cardiology - PRISM system monthly reporting</i>		100.00%	68.00%	92.90%	Not applicable Not a national priority for 11/12
Elective admissions cancelled on the day offered a date within 28 days <i>PAS and validation of clinical/non clinical reasons from specialty managers</i>		2.90%	5.00%	1.64%	Not applicable Not a national priority for 11/12
Delayed transfer of care - % of patients whose transfer was delayed <i>PAS</i>		4.09%	3.50%	2.37%	Not applicable Not a national priority for 11/12
A two-week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals. <i>CWT - Cancer system</i>		97.24%	93.00%	98.25%	93.00%
A maximum wait of one month from diagnosis to treatment for all cancers <i>CWT - Cancer system</i>		99.25%	96.00%	99.15%	96.00%
A maximum wait of two months from urgent referral to treatment of all cancers. <i>CWT - Cancer system</i>		91.20%	85.00%	92.69%	85.00%
Breast symptoms referred to a specialist who are seen within two weeks of referral <i>CWT - Cancer system</i>		95.11%	93.00%	95.77%	93.00%
31 days for second or subsequent cancer treatment(drug) <i>CWT - Cancer system</i>		100.00%	98.00%	100.00%	98.00%
31 days for second or subsequent cancer treatment (surgery) <i>CWT - Cancer system</i>		96.71%	94.00%	100.00%	94.00%
Patients with suspected cancer, detected through national screening programmes or by hospital specialists, who wait less than 62 days from referral to treatment <i>CWT - Cancer system</i>		97.10%	90.00%	98.92%	90.00%

Performance against key national priorities 2010/11 & Source of data	Performance	09/10 actual (if available)	10/11 targets	10/11 actual	11/12 plan
MRSA number of infections <i>APSH weekly HCAI Reporting</i>		9	5	5	4
Clostridium difficile <i>APSH weekly HCAI Reporting</i>		53	67	36	33
Number of diagnostic waits > 6 weeks <i>DM01 - monthly UNIFY returns</i>		0.00%	0.00%	0.00%	Not applicable Not a national priority for 11/12
18 weeks Referral to Treatment (RTT) Completed Pathways - Admitted patients <i>PAS - Referral to Treatment (RTT) database</i>		93.37%	90.00%	94.11%	95% of patients wait 23 weeks or less. The Trust will report on the average wait of 95% of our patients.
18 weeks RTT Completed Pathways Non-Admitted patients <i>PAS - RTT database</i>		97.87%	95.00%	98.19%	95% of patients wait 18.3 weeks or less. The Trust will report on the average wait of 95% of our patients.
MRSA Screening - Elective admissions <i>PAS and Microbiology database WINPATH</i>		99.10%	100.00%	99.40%	Not applicable Not a national priority for 11/12
Cancelled Operations <i>PAS and validation of clinical/non clinical reasons from specialty managers</i>		0.79%	0.80%	0.79%	Not applicable Not a national priority for 11/12
48 Hours GUM access <i>From Clinic and Information Systems Co-ordinator daily reports</i>		100.00%	100.00%	100.00%	Not applicable Not a national priority for 11/12

Statements on the engagement process for the development of the quality accounts

Ashford & St Peter's Hospitals NHS Foundation Trust Local Involvement Network (LINK):

The ASP Action Group have pleasure in commenting on the Quality Accounts prepared by the twin hospitals for 2011. One of our number joined the team invited to work on the initial drafting of these Accounts; he was surprised not to receive any further feedback thereafter, while we should all have welcomed more than 11 calendar days to prepare our response, with more than 500 words available to us. During the time allowed us, there has been a fruitful exchange of thoughts which we believe has made the LINK a useful contributor to these Accounts.

We are very impressed by the standard reached in this document. There is the right balance between what happened in the year 2010/2011 and what it is hoped will happen in the coming years, with in some cases targets set as far ahead as 2014. The language is clear and accessible, with jargon largely avoided (health service professionals must find it hard to remember that expressions such as “patient pathways” are not readily recognised by the public). The text includes all the information called for by the guidelines, the topics chosen correspond closely to those which we too consider most significant, such as discharge arrangements.

Certain details call for comment. In the first section, Graph one illustrates a decline over the three years shown in the (already small) category “Above Average”, although the hope is expressed that the hospitals will soon merit universal membership of this category. Perhaps the Accounts should explain how this is to come about. In the next four graphs we should have welcomed explanation of why 2009 was so poor compared to 2008 and 2010. Graph seven repays attention; in most months the numbers are identical year-on-year, so that it is three or four months which made all the difference, notably July, where in 2010 there were apparently no falls at all. There is a good section on A&E, which does not however mention the quite real problem of Mental Health patients who disrupt the department, for whom during the 128 hours of the week known as “out-of-hours”, no trained attention has been possible in the past. We know that an attempt is being made to address this issue, and consider the Accounts could have included this information.

We are concerned with the information presented on the length of stay in hospital, including a field where the results were not as good as hoped is admirably candid; this said, the analysis could have been better. It is not clear that the winter had much to do with the problem – December 2010 was indeed an appalling month*, but did not show up in the graph as significant, and patients getting older cannot occasion surprise. Our overall verdict must be to congratulate the hospitals on preparing such good Accounts, and to welcome the opportunity afforded us to contribute to them.

* Clarification provided by the LINK Chair dated 3 June 2011 ‘December 2010 was extremely cold, grey, and depressing. It could easily have led to an increased number of patients attending hospitals, but the numbers illustrated in the graph do not suggest that month was especially bad.’

The Overview and Scrutiny Committee:

No comment received

NHS Surrey Primary Care Trust:

NHS Surrey has reviewed the Ashford and St Peter's Hospitals NHS Foundation Trust Quality Account document for 2010–2011 and believes that this provides a fair reflection of the work of the Trust and includes the mandatory elements required.

We have reviewed the data presented and are satisfied that this gives an overall accurate account and analysis of the quality of services. This is in line with the data supplied by Ashford and St Peter's Hospitals NHS Foundation Trust during the year and reviewed as part of their performance under the contract.

We continue to work with the Trust to ensure that data accuracy and information governance at all levels remains a key priority.

The account identifies significant progress in relation to:

- Reduction of HCAI; MRSA and clostridium difficile levels compared to 2009-2010
- Ensuring that patients with a fractured hip that are fit for undergoing surgery get their operation within 36 hours of admission. It is noted that Ashford and St Peter's Hospitals NHS Foundation Trust is one of the best performing trusts in this area.

Ashford and St Peter's Hospitals NHS Foundation Trust has identified in its Quality Account a number of improvements in the patient experience evidenced in outcomes such as results of the National Inpatient Survey.

NHS Surrey will continue to work with Ashford and St Peter's Hospitals NHS Foundation Trust to raise the profile for quality improvement. The ongoing engagement of clinicians close working with primary care will remain crucial in monitoring standards and improving services for local people. The Trust is commended for their continued good work and emphasis on quality of patient care.

Having followed the framework with the Quality Accounts toolkit, we would like to share the following more specific observations:

Part 1	Statement on quality from Chief Executive, senior employee, stating document is accurate.	Statement, signed by CEO and senior clinical staff provided stating report content is accurate.
Part 2	Priorities for improvement	Compliant: Trust have identified 7 quality priorities for action for 2011/12, have set clear goals and have provided evidence of how these will be monitored and measured.
	Review of Services	Compliant: 6 key priorities for 2010/11 are reviewed

	Participation in Clinical Audits	Compliant
	National Audit	Compliant
	Participation in Clinical Research	Compliant
	CQUIN	Compliant
	CQC	Compliant
	Data Quality	Compliant
	Information Governance Toolkit	Compliant

2010/11 Statement of Directors' Responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
 - Board minutes and papers for the period April 2010 to June 2011;
 - Papers relating to Quality reported to the Board over the period April 2010 to June 2011;
 - Feedback from the commissioners- NHS Surrey- dated 02/06/2011
 - Feedback from Governors dated 18.05.2011;
 - Feedback from LINKs dated 01//06/2011;
 - The Trusts complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31 March 2010.
 - The national patient survey, 2010 (published April 2011);
 - The national staff survey, 2010 (published March 2011);
 - The Head of Internal Audit' s annual opinion over the Trust' s control environment dated 25/05/2011;
 - Care Quality Commission quality and risk profile dated April 2011;
- the Quality Report presents a balanced picture of the NHS foundation trust' s performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and

prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board:



Aileen McLeish
Chairman
2nd June 2011



Andrew Liles
Chief Executive
2nd June 2011

Your feedback

If you have any comments or suggestions on this Quality Account, we would welcome your feedback. Please contact: Suzanne Rankin, Chief Nurse via email: suzanne.rankin@asph.nhs.uk or telephone 01932 722216

You can get copies of this report in large print and other formats by calling 01932 722163

**Ashford and St Peter's Hospitals NHS Foundation Trust
June 2011**

This report was produced by the Communications Team, Ashford and St Peter's Hospitals NHS Foundation Trust, Guildford Road, Chertsey, Surrey KT16 0PZ

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